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# Independent sector treatment centres: evidence so far

The government plans to continue using NHS funds to contract with commercial healthcare providers in the second phase of the independent sector treatment centre programme, but **Allyson M Pollock** and **Sylvia Godden** argue that no good evidence is available to support this policy

The policy of the Department of Health in England is to use NHS funds to contract with for-profit multinational healthcare corporations to deliver clinical services. One controversial aspect of this policy is the independent sector treatment centre programme, which over the course of two phases (waves) will provide elective surgery and other services at a total cost of over £5bn (€6.7bn; \$9.7bn). The announcement by the secretary of state for health, Alan Johnson—that new contracts will be determined by local commissioners but second phase schemes will go ahead if they are value for money—makes a review of the evidence to support the policy timely.<sup>1-3</sup> This article assesses the programme in terms of the objectives set by the Department of Health<sup>4</sup>—that these centres should provide:

- High productivity
- High quality health care
- An increase in the number of medical professionals working in England (staff will come from overseas or be additional to the existing NHS workforce)
- Good value for money.

## History of the independent sector treatment centre market

The initiative was presented as a way to provide extra capacity to the NHS and reduce waiting times for elective surgery. The programme currently has two waves. The first wave, launched in 2003 was contracted to deliver up to 170 000 finished consultant episodes annually over five years, at a cost of £1.6bn. The second phase, launched in March 2005, should provide up to 250 000 additional elective and two million extra diagnostic procedures annually, over five years, at an estimated cost of around £4bn (£3bn for elective procedures and £1bn for diagnostics).<sup>5</sup> In July 2007, 24 centres, provided by seven for-profit companies, were operational.<sup>6</sup>

## Evidence on productivity

In addition to cost data, evaluations of productivity in the NHS rely on two key sources—bed data and admissions data.

## Bed data

Data on the number of available and occupied beds are collected annually from NHS trusts, but no such data are collected from independent sector treatment centres, although government policy is that they

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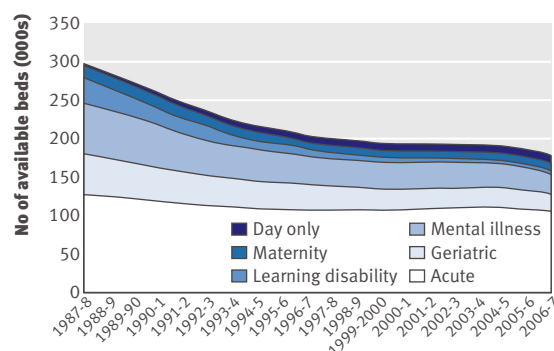
should be submitted as part of hospital episode statistics. Without these data it is impossible to assess the contribution that these centres make to capacity, productivity, or efficiency as extra beds, throughput, and bed occupancy cannot be measured.

Current government policy may be to substitute beds from the private sector rather than to provide extra capacity within the NHS. Overall, NHS capacity is decreasing, with a fall in the average daily number of available beds in NHS hospitals in England (including day beds) of over 23 000 (figure) between 1997 and 2006-7.

## Admissions data

The NHS in England requires all providers to make a data return on each patient. These returns are used to derive hospital episode statistics. They contain information such as diagnosis and procedure, age, sex, and residence, date of admission and discharge, and where treatment took place.

Although independent sector treatment centres are required to submit hospital episode statistics returns, data from these centres are not of comparable quality to those from the NHS, and the returns provide no comprehensive account of admissions and procedures undertaken. The Health Care Commission found that, of those independent centres submitting data for the period April to December 2006, 59% of episodes had no diagnosis, 18% had no procedure code, 60% had no pricing information (healthcare resource group), and 83% had not been assigned an ethnicity category. It also found that outpatient data from independent sector treatment centres were under-reported compared



Average daily number of available beds in NHS hospitals, by sector, England, 1987-8 to 2006-7. Taken from Department of Health, Hospital Activity Statistics, form KH03

with outpatient data from the NHS.<sup>6 7</sup> Incomplete and poor quality hospital episode statistics data limited the commission's ability to assess quality of care in centres.<sup>6</sup>

### Evidence on quality of health care

Measures of quality and performance—including readmission rates within 28 days, revision rates, perioperative mortality, and length of stay—all rely on hospital episode statistics data. Independent centres, however, have not been routinely providing good quality and complete data.

As part of the commercial contracting process the Department of Health Commercial Directorate established a separate reporting system for independent sector treatment centres based on 26 unpublished key performance indicators, around eight of which are clinical, but even these indicators are of variable quality.

The first research on the quality of work undertaken by private centres was carried out by the National Centre for Health Outcomes Development on four schemes (five providers) on the basis of the key performance indicator returns. Its report, published in October 2005, stated that data were so variable in quality and so incomplete as to render “any attempt at commenting on trends and comparisons between schemes and with any external benchmarks, futile.”<sup>8</sup>

The absence of systematic data about quality heightens concerns about standards of care. The House of Commons Health Committee in 2006 heard evidence suggesting that some independent centres offered seriously substandard care.<sup>9</sup> Professional bodies and associations had reported problems, including the use of foreign trained doctors unfamiliar with NHS surgical techniques, lax standards of vetting and training, lack of continuity of care, and a large number of pending litigation cases. The Royal College of Surgeons of England reported “increasing evidence” that these centres were unable to manage complications “with consequent transfer to existing NHS facilities and on occasions to the consultant to whom the patient was initially referred.”<sup>9</sup> The president of the British Orthopaedic Association submitted two dossiers of cases causing concern to the Department of Health, but lack of comparable routine data allowed the department to ignore the findings.<sup>10</sup>

### Evidence on increases in clinical staff

A key concern was that independent sector treatment centres should not employ existing NHS workers but should take on new staff. The additional policy

stated that private centres could not employ clinical staff who had worked in the NHS within the previous six months.<sup>11</sup> Exemptions were allowed under exceptional circumstances only. The policy of additionality has now been all but abandoned by the government, however, so that NHS employees who are not in “shortage professions” can be employed by private centres and NHS trusts can renegotiate contracts to allow staff to work in the private sector for some of their hours. Shortage professions have been redefined so that most NHS staff are now eligible to work in private centres,<sup>12</sup> and even those in shortage specialties can work during “non-contracted hours.”<sup>13</sup>

Workforce returns are made by the NHS to the Information Centre for Health and Social Care. We asked for similar data on the independent sector and were told that they are not collected at the moment, although this may happen soon.<sup>14</sup> The Commercial Directorate established new contracts last year, which require that workforce reports are collected from private centres.

A response to a freedom of information request in February 2007 indicated that around a quarter of full time clinical staff (doctors, nurses, and allied health professionals) working in private centres had been seconded from NHS trusts.<sup>15</sup> These numbers are likely to grow, as a leaked report forecast that the NHS was expected to shed more than 36 000 jobs last year and that by 2010-1 it will have 3200 more consultants than it can afford to employ.<sup>16</sup>

### Evidence on good value for money

#### Financial data

In an assessment of wave 1, the Department of Health refused to provide the Health Committee with financial information on private sector contracts and to supply the methodology underpinning value for money on the grounds of commercial confidentiality.<sup>9</sup>

In a supplementary written submission to the Health Committee, the department stated that value for money for private centres is calculated in relation to an “NHS equivalent cost.” But the cash components of this equivalent cost have not been made public. The then secretary of state for health Patricia Hewitt stated that the average premium for private treatment centres is 11% above the NHS tariff.<sup>17</sup> Centres also receive a subsidy (“premium”) to cover costs, such as bidding costs, incurred as private providers, but the actual amount is unclear.

#### Risk transfer

Risk transfer is a crucial element in value for money analysis of outsourced service contracts. When delays prevented private healthcare provider Capio from opening an independent sector treatment centre on time, Oxfordshire Primary Care Trust still had to pay Capio £1m for patients they should have treated in the delay period.<sup>18</sup>

Another key risk—that of clinical negligence claims—was assumed by private centres in wave 1 contracts but was transferred back to the public sector in July 2004. It was reported that insurance premiums for clinical negligence formed a large part of procedure

Procedures carried out by independent sector treatment centres to April 2007: cumulative totals

| Type of procedure     | To 31 December 2005 <sup>5</sup> | To 30 April 2006 <sup>20</sup> | To January 2007 <sup>21</sup> | To 30 April 2007 <sup>6</sup> |
|-----------------------|----------------------------------|--------------------------------|-------------------------------|-------------------------------|
| <b>Secondary care</b> |                                  |                                |                               |                               |
| Elective procedures   | 44 000                           | 59 960                         | 107 000                       | 167 850                       |
| Diagnostic procedures | 9 000                            | 25 151                         | 60 000                        | 307 435                       |
| All procedures        | 53 000                           | 85 111                         | 167 000                       | 475 285                       |
| <b>Primary care</b>   |                                  |                                |                               |                               |
| All procedures        |                                  | 11 679                         |                               | 140 485                       |

prices for private centres and that the change involved “significant” savings,<sup>19</sup> but the scale of the savings and who benefits have not been made public.

#### Demand risk and performance against contract

Demand risk, the risk to independent centres that fewer procedures than expected would be performed, was retained by the NHS from the outset. First wave contracts require the contracting primary care trust to pay independent centres for all procedures contracted for, whether or not they are carried out.<sup>9</sup> Evidence of underperformance on private contracts, which increases NHS costs, is also accruing.

The Commercial Directorate has a separate reporting system for private centres. Phase 1 contractual data to the end of September 2007, finally published on the Department of Health treatment centre website, claim 84% contract utilisation so far, with a total of 293 068 contracted diagnostics and 719 627 contracted procedures, broken down by individual contract. But these data do not conform to standard NHS reporting requirements and are not useful. We do not know what procedures were done or the cost or quality of the procedures, so we cannot gauge performance, productivity, or value for money. Furthermore, on the basis of the available data, independent centres performed far fewer than the annual 170 000 procedures contracted for, and two thirds of the total procedures were unspecified diagnostic procedures such as blood tests, radio-graphs, or scans—not surgical procedures (table).

#### Discussion

The Department of Health has failed to collect and provide data to allow evaluation of its policy of using for-profit commercial companies to deliver clinical services from NHS funds. One member of the Commons Health Committee remarked that the whole area seemed to be an evidence-free policy zone.<sup>22</sup> The failure to require independent sector treatment centres—which treat NHS patients—to provide data on the same basis as the NHS raises serious accountability issues. So too does government failure to collect and publish relevant data on the productivity, performance, and quality of these centres. Its refusal to provide data on the value for money of independent sector treatment centres is worrying, given that recent evaluations of Europe-wide attempts to improve health system efficiency by introducing consumer choice through market competition found no concrete evidence that the introduction or extension of choice “works.”<sup>23</sup>

In July 2004, a report commissioned by the Department of Health commercial directorate concluded that without contracts for at least a further 450 000 procedures a year, the private treatment centre market would “stagnate and eventually collapse.”<sup>24</sup> Although the phase 2 programme, which was to incorporate 24 schemes has been reduced to 15, the value of the £4bn contracts announced in 2005 has not changed.<sup>25</sup> While it is not possible to know what work private centres have been paid to do, the Healthcare Commission report showed that the government is also including



140 485 primary care procedures in the independent sector treatment centre data, even though primary care was not part of their initial contract.

Alan Johnson has declared that new private treatment centres will be established only with local agreement and if they provide value for money.<sup>26</sup> Value for money turns on risk transfer but the available evidence suggests that the real risks are being retained by patients, the public, and the NHS. The former secretary of state John Reid made a similar declaration in September 2003,<sup>27</sup> but some private centres were imposed on local primary care trusts, with little or no consultation with NHS staff or community representatives, and sometimes despite strong opposition.<sup>9</sup> Department of Health policy statements stress that strategic health authorities will be judged according to their primary care trusts' success in contracting with private providers.<sup>17</sup> In contrast, in Wales and Scotland NHS funds will not be used to enable private providers to compete with the NHS.<sup>28 29</sup>

Alan Johnson continues to provide new guarantees to the private sector. He recently announced that he will create a forum for independent sector providers to advise the department on local procurement practice; extend the NHS indemnity cover to non-NHS providers of NHS services; promote patient choice and make patients more aware that they can be seen by private sector providers free of charge; and continue to use the independent sector to help improve primary care services and provide additional general practitioner surgeries.<sup>30</sup>

#### SUMMARY POINTS

Using NHS funds to deliver NHS clinical services via the private sector lacks evidence and has not been evaluated

Data to support government claims that independent sector treatment centres offer high productivity, high quality health care, or value for money are lacking

Such centres are meant to provide extra capacity and staff, but 23 000 NHS beds in England have closed and many NHS clinical staff have transferred to the private sector since their introduction

Patients', lawyers', and professional bodies' concerns over quality and safety are being ignored by government



The recent announcement by the Department of Health of the framework contract under which 14 private sector companies including Bupa, Tribal, and United may manage up to 70% of the total NHS budget for care, combined with the current roll out of contracts to commercial companies such as Virgin and Atos for primary care and general practice, shows the strength of the government's determination to privatise the delivery of NHS health care.<sup>31</sup> The department has put in place a platform of private providers that will enable this to happen. As the BMA reported to the Health Committee, "the independent sector treatment centre programme has developed well beyond the original undertaking to provide additional capacity and instead will see large volumes of activity and staff transferred . . . to the private sector."<sup>5</sup>

**Contributors and sources:** AMP and SG have extensive experience of research in the NHS and social care. The research was carried out using publicly available information including official government documents. AMP designed the research, SG gathered data, and both authors analysed the data and drafted the paper. AMP critically revised it and approved the final version. Stewart Player, a research assistant in the centre and Colin Leys drafted an earlier research report on independent sector treatment centres. Their report provided some of the background research and material on value for money and government policy objectives. AMP is guarantor.

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## Ashes to ashes

Some readers may be familiar with Ash Wednesday, when members of the Roman Catholic community in Northern Ireland have charcoal placed on their foreheads as symbolic of the beginning of Lent. As time has gone by, this has become an overt statement of allegiance in certain areas.

I was working at a hospital when one such patient arrived with a huge mark on his forehead. After his eye examination, I wiped down the slit lamp and called the next patient for review of his retinal symptoms. His tattoos, football shirt, and lack of ash, made it clear he was from a different community.

The retinal check finished, I started to tell the patient that all was well. I was horrified to realise that I had forgotten to wipe down the headrest before examining him. A heavy handed priest had put so much ash on the previous patient that it had transferred to the head rest and now sat resplendent on the head of my Protestant patient identifying him to all as a member of a different community.

What was I to do? The situation could turn nasty if he saw himself in a mirror or if family members in the waiting room saw this "conversion." Other patients' banter could easily lead into chaos. Thankfully the man had fluorescein dye around his eyes so, under the guise of wiping this off, I succeeded in wiping his forehead clean.

Obviously one learning point is to clean slit lamps properly between patients. More importantly, we must be alert to the sensitivities of the communities we serve. Having been brought up in Northern Ireland, I was aware of the connotations and potential upset such a simple matter could cause. I wonder if doctors from the UK mainland or of other nationalities would have been so aware.

Our medical skills offer each of us a passport all over the world, but we should temper our universality by considering the traditions of the population we work for.

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